From:	Charles Bailey
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	IRS Form 990 Redesign - Comments by Texas Hospital Association
Date:	Wednesday, September 12, 2007 12:10:55 PM
Attachments:	THA Comments - Form 990.doc

On behalf of the Texas Hospital Association and its more than 400 member hospitals, I am submitted the attached comments on the draft Internal Revenue Service Form 990 and related schedules. Should you have questions concerning our comments or recommended changes to the form or schedules, please contact me.

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September 12, 2007

Via Electronic Filing

Mr. Ron Schultz
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comments on Draft Form 990 and Schedules

On behalf of the Texas Hospital Association and its more than 400 member hospitals, we appreciate the opportunity to provide comments on the draft Internal Revenue Service Form 990 and related schedules. Our comments will focus on Schedule H for Hospitals; however, we are also submitting a number of general comments on the core Form 990 and other schedules.

Texas hospitals support the guiding principles upon which the revised Form 990 is based and commend the IRS for its efforts to update the reporting requirements for tax-exempt organizations. In 1993, THA and our nonprofit hospital members worked with the Texas Legislature on the enactment of a comprehensive state law that established new requirements for tax-exempt hospitals to plan for, provide and report charity care and other community benefits. In many respects, the proposed Scheduled H incorporates elements of the Texas reporting process. While we are supportive of those parts of the revised Form 990 and schedules that promote transparency and compliance, some of the proposed reporting is not relevant to nonprofit hospitals' charitable purpose and will unnecessarily increase the administrative burden associated with completion of the forms.

Comments and Recommended Changes to Core Form 990

1. Part II will require the submission of compensation information on "officers, directors, trustees, and key employees." While this is the same group of individuals for whom information has been collected in the past, the definition of "officer" and "key employee" is not clear and has led to confusion and inconsistency in reporting. Historically, some tax-exempt organizations have taken the position that the term officers include only individuals appointed by the organization's board of trustees as "officers" under state law. Other organizations have reported all individuals who have an officer title (e.g. vice president, senior vice president etc.) regardless of whether they have been designated as officers under state law. The two glossary definitions provided with the revised form do not clearly specify which of these historical practices is correct. The instructions should be clarified so that all organizations consistently report officer related information. In addition,

consideration might be given to the establishment of a requirement that a key employee or officer must be authorized to approve a certain level of expenditure on behalf of the organization prior to be included in the Part II disclosure.

2. In Part II, Section B, an organization is required to indicate on line 8 whether any individual listed in Section A received more than $250,000 of reportable or other compensation, including deferred compensation, non-taxable fringe benefits and expense reimbursements. If so, Schedule J must be completed. We believe that both here, in establishing the $250,000 threshold, and on Schedule J, only taxable expense reimbursements should be included. As these terms are defined in the proposed instructions, every meal served at a lunch meeting attended by an officer would need to be quantified and reported as an element of compensation. The inclusion of non-taxable expense reimbursements and non-taxable fringe benefits will significantly increase the compliance burden on tax-exempt hospitals without providing commensurate benefit to the public.

3. In Part III, an organization is asked on line 3b how many transactions were reviewed under its conflicts policy. We believe this question should be deleted because answers to this question could be easily misconstrued. If the organization responds that a large number of transactions were reviewed, it will be unclear to the public whether the organization is hyper-diligent and reviews every transaction that remotely raises a conflict issue or that there are a significant number of true conflicts that should be reviewed. In contrast, if the answer is zero there may be the perception that the board is failing to review potential conflicts. Without the opportunity to explain the context of the answer, we believe that reporting only the number of transactions reviewed provides no useful information and, worse, provides information that could be misconstrued. Rather than using this particular metric as a proxy for the effectiveness of an organization's conflict of interest policy, organizations could be asked to disclose the number of individuals that are required to complete conflict of interest questionnaires/disclosures under the organization's conflict of interest policy.

4. One of the deficiencies of Form 990 is that it fails to appropriately acknowledge that many tax exempt entities are a part of a larger corporate structure and that each of the corporations within this corporate structure is required to file a separate Form 990 and applicable schedules. This piece meal reporting by the corporate parent and each of the subsidiary corporations may provide an incomplete picture of the business activities of these corporations and how they are jointly fulfilling their tax exempt purpose. In addition, a number of the questions relating to governance, management and financial reporting are structured in such a manner that a correct answer by a subsidiary corporation will provide an inaccurate assessment of the governance and oversight of the organization's activities. For example, within a multi-hospital system much of the financial reporting and oversight of financial statements is done at the corporate parent level and each of the subsidiary corporations may not have an audit committee. To address this issue, we recommend that questions be added to Part III, which will allow organizations to better describe their governance and management structure. Specifically, we recommend that the following new questions #8 and #9 be added to Part III and the subsequent questions are appropriately re-numbered. In addition, we recommend that existing question #9, which would be renumbered as question #11 if the prior recommendation is accepted, be modified to allow the organization to explain that the audit of financial records is conducted at the corporate parent level.

8 a Is the organization the parent corporation within a multi-corporate structure?

b If yes, does the organization have written policies and procedures governing the activities of the subsidiary corporations to ensure that their operations are consistent with the organization?

9 a Is the organization a subsidiary corporation within a multi-corporate structure?

b If yes, does the parent corporation have written policies and procedures governing the activities of the subsidiary corporation to ensure that their operations are consistent with the parent corporation?

11 a Does the organization have an audit committee?

b If no, is there an audit committee of a parent corporation that reviews the financial statements of the organization and other subsidiary corporations?

General Comments on Schedule H - Hospitals

It is our understanding that the American Hospital Association has submitted detailed comments on Schedule H relating to hospital organizations and the Texas Hospital Association generally supports those comments. As emphasized in the AHA letter, completion of Schedule H will impose a new and significant administrative burden on hospitals. In addition, the information requested fails to provide reviewers with a complete view of the activities of nonprofit hospital systems as each individual corporate entity within the system must generally file separately. The lack of a system filing option may lead the IRS to suspect noncompliance when none was present. Further, some of the information will be presented in a misleading and overly abbreviated manner that tends to confuse instead of inform reviewers.

Consistent with the comments received from the AHA, we believe that required use of Schedule H for the 2008 tax year is unrealistic and that the timeframe for implementation of this schedule should be extended to tax year 2010. Given the number of concerns and questions that will be raised concerning Schedule H, it is likely that modifications will need to be made to the instructions, definitions and worksheets. Even if the IRS finalizes the schedule and related documents in early 2008, hospitals must be given a reasonable period of time to reconfigure their financial and data reporting systems and to train staff on completion of the schedules. Second, Schedule H should be appropriately modified to allow hospitals the opportunity to provide information on the full range and value of community benefits provided. While it is recognized that the IRS will receive differing positions from the hospital community concerning whether Medicare underpayments and bad debt should be considered a community benefit, we believe that this data should be reported to provide a more complete picture of nonprofit hospitals' financial condition and give the public and policy makers the opportunity to review and consider this information. Finally, those parts of the schedule that are unrelated to community benefit or compliance should be deleted or moved to other more appropriate schedules.

Specific Comments and Recommended Changes to Schedule H

As currently drafted, Schedule H must be completed by any entity that "operates or maintains a facility to provide hospital or medical care." This question is much too broad and will require facilities that are not hospitals to complete Schedule H. We believe that the question on Form 990,

Part VII, Line 9, should be reworded as follows: "Does the organization directly operate a hospital? If yes, complete Schedule H."

In addition, the term "medical or hospital care" and its definition should be deleted from the glossary. The glossary term "hospital facility" should be changed to "hospital" and the definition reworded as follows:

A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities that provides medical, nursing, and related services for ill and injured patients twenty-four hours per day, seven days per week. A hospital does <u>not</u> include:

- A nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)
- Free-standing outpatient clinic
- Community mental health or drug treatment center
- Physician group practices/faculty practice plans
- Physician offices
- Facility for mentally retarded/developmentally disabled
- Facility for treating alcohol and drug abuse
- Hospital wing of a school, prison, or convent

In addition, by re-phrasing the question to inquire whether the organization directly operates a hospital rather than "is the organization a hospital", the question will include organizations that operate a hospital and also perform other exempt functions. For example, a private university that operates a teaching hospital would answer this revised question in the affirmative. If the question is left as "is the organization a hospital," a university might not prepare Schedule H for its teaching hospital as it might deem itself a school rather than a hospital. Finally, adding the word "directly" makes clear that "parent" organizations of one or more hospitals would not themselves have to complete Schedule H.

Part I – Community Benefit Report

1. The collection of data under column headers – (a) Number of activities or programs, and (b) Persons served – will have limited value in the assessment of a hospital's provision of community benefits and based on how the instructions are interpreted there could be considerable variance in how these data fields are completed by hospitals. Further, it is uncertain how a hospital would determine the number of persons who were served by or benefited from a hospital's education or research activities. However, the required collection and reporting of this data will increase the costs associated with completion of the schedule. Therefore, we would recommend that these columns be deleted for this section of Part I.

   Additionally, the methodology used to count persons served is often inconsistent from hospital to hospital and is very difficult to track. For example, if a single charity patient visits the hospital five times in a year, is that one person served or five? Does it matter if the five visits are for the same diagnosis or different diagnoses? Some hospitals track "encounters" or "discharges" but even these are not universally defined from hospital to hospital. Further, neither "persons served" nor the more commonly tracked "encounters" or "discharges" make sense for some of the community benefit categories.

2. On line 1, hospitals are required to report the amount of charity care at cost based on the calculation of this amount in worksheets 1 and 2. Worksheet 2 establishes a complex and potentially confusing formula for the calculation of a cost-to-charge ratio. While the formula for the calculation of the ratio was taken from the Catholic Health Association *Guide for Planning and Reporting Community Benefit*, there is no guidance in the CHA Guide or in the IRS instructions for Schedule H on how this worksheet should be completed. Many of the terms that are to be used in the calculation of adjusted total operating expenses are undefined and it is questionable whether the various adjustments should be made in the calculation of this amount. In addition, it is important to note that the application of a cost-to-charge ratio to the charges applied for charity care services is intended to provide a proxy for the costs incurred by a hospital in providing these services and an overly complicated formula is unnecessary and may result inconsistent or inaccurate reporting of charity care costs. We recommend that the formula for calculation of the ratio be simplified as follows: ratio = total operating expenses/total gross charges.

3. On line 3, hospitals are required to report the amount of unreimbursed costs from other governmental programs based on worksheet 3. This worksheet provides that the unreimbursed amount should be calculated based on information from the hospital's cost accounting system or the program cost report. Unlike the Medicaid program, many of the state or local governmental programs do not utilize a cost report in the determination of hospital reimbursement rates, and not all hospitals currently have a cost accounting system. Therefore, we recommend that worksheet 3 be revised to allow the determination of unreimbursed costs for these other governmental programs to be calculated based on a cost-to-charge ratio utilized to calculate the unreimbursed cost of charity care. To simplify the determination of unreimbursed Medicaid costs the same cost-to-charge ratio could be used for this calculation also.

4. On line 5, hospitals are required to report the amount of community health improvement services and community benefit operations from worksheet 4. While the instructions state that community health improvement services extend beyond patient care activities, the instructions do not clearly indicate what types of services that might be included in this category of community benefits. Hospitals currently provide a broad range of services to the communities they serve, including: community health information; education of patients on specific medical conditions and treatment options; and preventive health services (i.e., immunizations, wellness programs, accident prevention, family violence prevention and counseling). In addition, hospitals expend resources to recruit physicians, nurses and other health care professionals into their community and the recruitment of these providers will result in improved access to services and improved community health. The definition of "community health improvement services" should be expanded to include reference to these types of services.

5. On line 9, hospitals are required to report the amount of cash and in-kind contributions made to other community groups from worksheet 8. Similar to our comment on the reporting of community health improvement services, we believe that the definition of "cash and in-kind contributions to community groups" should be expanded to include the full range of potential contributions that might be made by a hospital to other groups. For example, this definition should include: donation of the use of hospital facilities; donation of equipment, supplies or food; donation of personnel; and financial support of community health or educational programs conducted by other organizations.

6. At line 10, a new category of benefit should be added to reflect community building activities undertaken by nonprofit hospitals. A "community building" category would appropriately include activities that are designed to address some of the root causes of illness and disease and will promote health within the community. For example, community building services might include programs to address public health concerns (e.g., water quality, removal of lead paint in schools or housing) or financial support of low-income housing, job training programs and economic development.

7. At line 12, a question is posed concerning the preparation of a community benefit report and whether the report is available to the public. While this question is reasonable and appropriate, this section of the schedule should be expanded to allow hospitals to provide additional information regarding its assessment of community needs, the development of a community benefits plan and budget, and whether these plans or reports are reported publicly and, thus, available from a state regulatory agency. In addition, hospitals in a number of states, including Texas, are required by state law to provide a specified level of charity care and other community benefits. An inquiry concerning whether a hospital is in compliance with any state requirements would provide additional information to the public concerning its provision of charity care and community benefits Specifically, we recommend that the following new questions be added to this section of Part I of the schedule:

   Does the organization conduct a community needs assessment?
   If yes, describe how the organization conducts the assessment

   Does the organization file a community benefits report with a local or state regulatory agency?
   If yes, is the organization in compliance with the local or state reporting requirement?
   If yes, identify the agencies to which the report is filed.

   Is the organization required to provide a specified level of charity care and community benefits in order to maintain its tax exemption under state law?
   If yes, is the organization is compliance with the state law requirement?

8. On line 13, hospitals must indicate whether a charity care policy has been adopted by the hospital and then asked to describe the policy. This question is important, but it may not be possible for hospitals to adequately describe the details of its policy in the limited space allotted. In addition, the inquiry concerning any type of aggregate budget cap or limitation on charity care services will be difficult to answer. Due to the complexity of hospital charity care policies, the more appropriate question may be whether the organization makes the policy available to the public and how it is made available. If it is determined that hospitals should be required to describe their charity care policies, we would recommend that part (c) of the question at line 13b be modified to inquire whether the hospital budgets annually for charity care, and that additional lines be provided for hospitals to describe their policy.

9. Following the questions relating to charity care policies, we believe it is important for a question to be posed concerning any policy that has been established to provide discounted services to uninsured patients. In Texas and in many other parts of the country, there are many people who are not covered by a governmental or private health insurance program and hospitals provide a significant amount of free or discounted services to these individuals. While these discounted services will not technically qualify as charity care

since the discount is provided to those patients who exceed the eligibility guidelines set forth in the hospital's charity care policies, the willingness of nonprofit hospitals to provide services at a discount helps these individuals to gain access to needed services. Specifically, we recommend that the following question be added to this section of Part I of the schedule:

Does the organization have a policy to discount its charges for services to uninsured patients?
If yes, describe.

Part II – Billing and Collections

In Part II, Section A, hospitals are required to provide information concerning its charges, discounts and anticipated payments from various payor sources. While this information may provide the public with some understanding of a hospital's payor mix, it has no relation to the providing of community benefits by hospitals and will merely increase the costs incurred by hospitals to complete the schedule. In addition, the proposed classification of patients as "insured" or "uninsured" is not consistent with how hospital billing systems track patients and it will not be possible for hospitals to report data in this manner without changes to these billing systems, which will be expensive and burdensome to implement. Therefore, we recommend that this section be deleted.

Part III – Management Companies and Joint Ventures

Part III requires hospitals to provide information concerning management companies or joint ventures that are owned by officers, directors, trustees, key employees or physicians who have staff privileges and which provide specified services. Similar to the question concerning hospital billing and collections, this part is not relevant to the providing of community benefits by hospitals and should be deleted. In the alternative, this part should be moved to Schedule R and answered by all nonprofit organizations.

Part IV – General Information

For a number of questions in different parts of Schedule H, hospitals are not allotted sufficient space to fully describe its organizational structure, how policies and procedures are established, and the various community benefits provided. This part should be appropriately expanded to allow this type of elaboration by hospitals. Specifically, we recommend that the following new questions be added to Part IV:

Is the organization the parent corporation of a multi-hospital system?
If yes, does the organization have written policies and procedures governing the activities of the hospitals within the system to ensure that their operations are consistent with the parent organization?

Is the organization a part of multi-hospital system?
If yes, does the parent corporation have written policies and procedures governing the activities of the organization to ensure that its operations are consistent with the parent corporation?

Does the hospital have a governing board that establishes written policies and procedures governing the operations and activities of the hospital, including policies relating to charity care and community benefits?

Does the hospital have an open medical staff with privileges available to all qualified physicians in the area?
If no, explain

In addition, question #3 on hospital emergency room policies should be modified. As currently written it is overly broad and would require hospitals to describe every policy and procedure in a very limited amount of space. We recommend that the question be revised as follows:

Does the organization operate an emergency room?
If yes, is it operated 24 hours a day?

Other than being at capacity, did your emergency room deny services to anyone who needed services?
If yes, explain

Finally, we would recommend that a check list of potential community benefits be included at the end of Part IV to allow hospitals the opportunity to provide information on the full range of community benefits being provided. The use of a checklist may be a more effective way to portray this information rather than a general question that asks the hospital to provide any other information that describes how the organization furthers its exempt purpose.

Comments and Recommended Changes to Schedule J

As discussed above, we recommend that Column E that requires information relating to nontaxable expense reimbursements be deleted from this schedule. Based upon the proposed definition of non-taxable expense reimbursements, the compilation of this information will be extremely burdensome. In addition, the inclusion of this data may lead the public to incorrect assumptions about amounts paid to certain officials or staff of an organization. In addition, this type of inquiry is addressed in questions #2 and #3 of the schedule that ask about reimbursement policies of the organization.

Comments and Recommended Changes to Schedule R

Part V of Schedule R requires the disclosure of information among related organizations. For hospitals within a multi-hospital system there are a very significant number of transactions that occur on a regular basis between the various hospitals in the system and the corporate parent. To require information on each of these transactions would be extremely burdensome and would provide the IRS and the public with little useful information. We recommend that the instructions for Schedule R be modified to clarify that Part V does not apply to transactions among related organizations that are wholly owned by a single corporate parent.

In closing, we would respectfully request that these comments and others submitted by hospitals and hospital associations be carefully considered and that appropriate changes be made to Schedule H and other parts of the Form 990. We hope that our comments and our recommended changes will help improve the quality and usefulness of the form. Should you have any questions concerning our comments, please feel free to contact me at (512) 465-1038.

Sincerely,

Charles W. Bailey

Charles W. Bailey
Senior Vice President/General Counsel

From:	mcphersonbruce@aol.com
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on the IRS Proposed Form 990 Redesign
Date:	Wednesday, September 12, 2007 10:20:57 AM
Attachments:	AllianceComments-IRSProposedForm990Redesign.doc

Attached please find the comments of the Alliance for Advancing Nonprofit Health Care, which represents all types of nonprofit health care organizations, on your proposed Form 990 redesign.

We appreciate the opportunity to comment. The IRS is to be commended for this major and complex undertaking. It is a good beginning, we believe, but there are many areas where significant improvements are needed. We urge that implementation be delayed a year to provide both the IRS and exempt organizations the time they need to accomplish this major reform in an efficient and effective manner.

We would be pleased to work with you on any and all of the areas of concern noted in the attached.

Thank you.

Bruce

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September 12, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
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Subject: Comments on the Proposed Form 990 Redesign

The Alliance for Advancing Nonprofit Health Care, representing all types of nonprofit health care providers and health plans, appreciates the opportunity to provide these comments on the proposed Form 990 redesign.

We commend the Internal Revenue Service (IRS) for this major, complex undertaking, and overall, we view the proposal in its entirety as a good first effort. Notable positive changes include but are not limited to:

- Creation of a Schedule H for more uniform reporting by nonprofit hospitals on the community benefits they provide, using as a foundation guidance developed by the Catholic Health Association (CHA) and VHA, Inc. We are also pleased that this Schedule includes a question where the organization can report other, including non-quantifiable, community benefits furthering its exempt purpose.

- Creation of a Core Form that includes information on the filing organization's mission and achievements and that provides a reasonably structured, high-level, overview of the organization.

We recognize the extremely difficult balancing act involved in trying to meet all three of your stated goals: improving transparency, promoting compliance, and minimizing reporting burdens. We applaud those goals. In fact, we support some additional reporting burdens on nonprofit health care organizations, especially nonprofit hospitals, to achieve the other two goals. However, some of the reporting burdens being proposed are excessive. Many of the new questions and instructions are ambiguous, and some embody metrics (e.g., numbers, percentages) that could easily be misinterpreted. Some questions appear to be indirectly implying a new IRS policy regarding desirable or undesirable

behavior, and if that is the case, the IRS needs to come forward with explicit proposed new compliance guidelines for public comment before querying such areas in a redesigned Form 990. In other cases, more space is needed for an answer or a means should be provided for the organization to attach documents or link the reader to documents on the organization's web site.

We are also very concerned about the implementation timing for the redesigned Form 990, as well as any restrictions that may be contemplated on the ability of parent organizations to file in an aggregated manner.

Implementation Timing

The IRS has indicated the intent to use the redesigned Form 990 for the 2008 tax year (returns filed in 2009). That time frame is wholly unrealistic and inappropriate, given the time it will take for the IRS to analyze all the comments and make all the appropriate changes in the documents, and then for all nonprofit health care and other exempt organizations to make all of the necessary changes in their own internal financial and other data record-keeping. At a minimum, the redesign should be delayed until the 2009 tax year (forms filed in 2010), especially for all of the new forms and schedules and those that are undergoing major change.

Filing Entity

Parent organization filers with multiple entities under a single EIN should continue to be given the option of filing as an aggregate entity or filing separately for each of its component entities, whichever way they believe will better inform the public about their organizations. For those filing in aggregate, the IRS always has the option of requesting information on the individual component entities.

Core Form

The term "significant" in Question 2 of Part I (list the three most significant activities) requires clarification. Does the IRS intend that the organization base significance on some particular criterion or criteria? Question 2 in Part IX (statement of the most significant program service accomplishments) should be moved to the Part I Summary, which is the section which the general public is most likely to read. Also, more space should be provided for the organization to describe both its three most significant activities and its most significant program service accomplishments. In addition, the references to "Code" in Question 2 of Part I and "Activity Code" in 3a, b and c of Part IX should be explained or deleted.

Unless there is a specific need for Question 5 of Part I (asking for the total number of employees), which has not been explained, it should be deleted.

In Question 6 of Part I and Question 2 of Section A of Part II, the compensation threshold for reporting numbers of individuals should be changed to at least $150,000 (from

$100,000) or indexing this threshold across area labor markets and organization sizes to enhance its relevance, thereby (a) simplifying reporting; (b) focusing on the individuals for which detailed information is sought in Schedule J; and (c) recognizing appropriate compensation levels for large, complex, and/or urban nonprofits. The raw number of persons earning over $100,000 provides no meaningful information.

Question 8b in Part I should be deleted, because the percentage of total revenues related to leadership compensation is ambiguous at best, and irrelevant at worst. The percentage will vary so widely over the diverse universe of nonprofits as to be meaningless and could lead readers to draw unwarranted conclusions.

Questions 9 through 24 of Part I and Schedule D (Financial Statements), as well as the instructions related thereto, should be revised such that all of the financial information requested will be wholly compliant with Generally Accepted Accounting Principles (GAAP). Meaningful comparisons will not be possible without compliance with GAAP, which encompasses rigorous requirements on content and presentation and is well understood by most providers and users of financial information. It makes no common sense to use any other basis for Form 990 reporting of financial information.

No rationale is provided for separating out gaming from other fundraising in questions 25 and 26 of Part I. Also, either column (iv), requesting a percentage, should be eliminated or space should be provided for comments, as a low percentage could be erroneously perceived as poor performance. For instance, in the early stages of a major, multi-year capital fundraising campaign, expenses will tend to be higher in relation to donations.

Language should be added to Section A of Part II stating that Schedule J must be completed for all persons listed in Section A. The request in Section A of Part II for "City and State of Residence" should be deleted to protect the safety and security privacy rights of these individuals**.** If the IRS can provide a reasonable justification for this information, such information should be requested through some other means that will not be made public.

Question 5 in Section B of Part II should be reworded to apply to only current officers, directors and key employees, as it is unreasonable to expect that a nonprofit organization will have or could reasonably obtain such relationship information about all former officers, directors and key employees over the past five years. In addition, the term "business relationship with any other person listed in Section A" requires clarification, as it could be broadly interpreted to include such transactions as the purchase of goods or services by one board member or employee from a banker, car dealer, or a utility company CEO who is a member of the board, which we do not believe is the IRS' intent.

Question 6 in Section B of Part II also appears to seek information that the organization is unlikely to have or could not reasonably be expected to obtain. Perhaps it could be reworded to read: "Did the organization enter into an arrangement with another organization for compensation of one of its officers or directors for services rendered to the filing organization? If yes, include these individuals on Schedule J."

Questions 7 and 8 in Section B of Part II are unnecessary and should be deleted.

In various parts of the Core Form related to compensation and Schedule J, and the instructions related thereto, there should be one clearly defined, consistently used, set of terms for officers, directors, key employees and disqualified persons. Moreover, the definition of officers in the glossary is unnecessarily and inappropriately broad, and should be confined to corporate officers as designated in governance documents and any applicable state laws.

In Part III a number of questions are ambiguous, a new proposed IRS policy appears to be implied, and/or the responses could be misinterpreted. In particular:

- Question 3a should be reworded because it does not indicate if such a policy is for employees and/or board members. We recommend the following language: "Does the organization have a conflict of interest policy or policies for both employees and board members?".
- A "0" answer to Question 3b could indicate that the filing organization had no potential conflicts of interest in the filing year – good – or that the organization failed to implement its policy – bad. This question should be deleted.
- The basic rationale for question 8 is unclear, as is the term 'prepare". This question should be deleted or replaced by the question that is currently asked, "Who is responsible for your financial records?".
- The term "reviews" is unclear in Question 10. Is the IRS asking whether, or implying that the organization should, have all board members review in advance the entire Form 990, that a line-by-line presentation of the proposed filing be made at a board meeting, that some committee review the entire proposed filing, etc? If the question is to be retained, it should be reworded to ask "How was the organization's governance involved in review of information to be included in Form 990 before it was filed?". Space should be left for the organization to reply accordingly.
- Question 11 inappropriately conveys the impression that a nonprofit's governing documents, conflict of interest policy, and audit report *should* necessarily be made public when there is no legal obligation to do so. It also fails to provide appropriate guidance to filing organizations regarding how certain available documents, such as the 990, *must* be made public. In addition, it places an inappropriate burden on the filing organization to attempt to identify what "other website(s)" the documents appear on. This question should be revised to ask about Form 990 and Form 990-T per se, with the answer options revised as follows:

    - delete "n/a";
    - "organization's website"
    - delete "other website"
    - "office"
    - "other _____"

Question 18 of Part V should be either deleted or revised and moved to Schedule C where it could be properly addressed. The question asks about "travel or entertainment

expenses" for any federal, state or local public official but those terms are not well defined. Both federal and certain states' laws expressly permit elected officials to accept complimentary tickets to charitable events that may include entertainment. Does the IRS anticipate that the cost of such complimentary tickets (above the individual $200/aggregate $1,000 expenditure limits) should be included in the answer to this question? A better approach might be to require reporting of all expenditures that have been reported for the calendar year to federal, state, and local government lobbying oversight agencies. Otherwise, guidance is needed on how to calculate the value of complimentary tickets.

Question 21 in Part V, payments to affiliates, needs to be clarified. Large organizations typically have numerous shared services between linked entities that flow through intercompany accounts. Quantification of these transactions in aggregate would be meaningless.

In question 8a of Part VII, the term "substantial part" of exemption operations needs to be clarified.

Schedule C

Given that federal, state, and local government definitions related to, and thresholds for, lobbying activity differ, and that a principal consideration behind the Form 990 revision is to minimize the burden on filing organizations, Schedule C should be revised to require reporting of all lobbying expenditures that have been reported for the calendar year to federal, state, and local government lobbying oversight agencies.

Schedule H

The proposed Core Form, Schedule H and the Glossary provide conflicting language regarding the types of tax-exempt health care providers that would be required to complete Schedule H. The language in all these documents should be modified to clearly and consistently indicate that Schedule H applies only to organizations providing hospital inpatient acute care services[1]. The following specific language changes should be made:

- Delete "medical care" in question 9 of Part IV of the Core Form
- Replace the language in the Glossary and in instructions for Schedule H stating that "medical or hospital care … includes the type of care provided by hospitals, rehabilitation institutions, outpatient clinics, skilled nursing facilities, and

[1] For instance, nonprofit nursing facilities and hospitals operate under different IRS revenue rulings and requirements for federal tax exemption. The revenue ruling that is the basis of the community benefit standard for hospitals (69-545), and the proposed Schedule H, is not relevant to nursing facilities and elderly housing. The revenue rulings that guide federal tax exemption for nursing homes and elderly housing (72-124 and 79-18) do not include the community benefit requirements of hospitals. Moreover, hospitals and long term care facilities are serving a different need and purpose. Schedule H is designed for hospitals, not home health agencies, community health centers, or long term care facilities. In addition, public concerns giving rise to Schedule H have been restricted to nonprofit hospital community benefit practices.

community mental health or drug treatment centers … (and) that treat any physical or mental disability or condition, whether on an inpatient or outpatient basis" with the following language:

- "A facility that provides hospital care is one that provides emergency and inpatient acute care whose length of stay is not limited by statute or rule" or
- "A facility that treats any physical or mental disability or condition on an inpatient acute care basis. Such facilities include those operated by non-medical organizations (e.g., colleges, prisons).

Schedule H should add from Form 1023, Application for Recognition of Tax-Exempt Status, Schedule C, the traditional factors considered for compliance related to emergency room operation, governance, open medical staff, etc.

Community-building/community development initiatives should be specified as an additional separate category of community benefit, using the definitions and examples for this category developed as guidelines by the CHA and VHA, Inc. Such initiatives can be critical to preventing illness and improving the overall health and well-being of the community, and must not be ignored in assessing the social value and performance of the organization.

Underpayments by the Medicare Program should be as reportable as a community benefit any other other government program underpayments. The American Hospital Association estimates that aggregate Medicare payments are about 92% of costs, with almost 70% of hospitals experiencing Medicare losses. If the system were fair, one would not expect such a high percentage of hospitals experiencing losses. Moreover, if the system were fair, the Center for Medicare and Medicaid Services would not have needed to undertake its current initiative to significantly reform the DRG patient classification system.

Part II of this Schedule, labeled Billing and Collections, needs to be substantially revised. The table under Section A asks for data that is irrelevant and that would be extremely difficult for any hospital to provide. This Part, as well as questions 13a and b under Part I and Question 2 under Part IV, should be deleted in favor of two basic questions:

- Does the organization have a written billing and collections policy, including the provision of financial assistance for those unable to pay?
- How does the organization make known such a policy to patients and the broader community?

Part II, Management Companies and Joint Ventures, does not belong in this Schedule. If the information is needed, it should be integrated into the Core Form or Schedule R and made applicable to all tax-exempt organizations required to file Form 990.

Schedule J

This schedule and its instructions need to be revised to eliminate the possibility of "double-counting" deferred compensation across time periods.

In addition, the terminology in questions 4 and 5 regarding "pay determined in whole or in part by the revenues or net earnings" is unclear. Such questions should not be included in Form 990 documents unless and until the IRS has issued clear guidelines on what specific types of arrangements it believes should and should not be allowed in exempt organizations.

Schedule K

This schedule requires extensive information for each outstanding bond issue in excess of $100,000 on the last day of the taxable year, some of which is already available through Form 8038 which is filed when bonds are issued. Moreover, it would be extremely costly if not impossible to obtain all of the information requested on past bond issuances, as organizations were unaware that such information would ever be required to be reported to the IRS. Accordingly, the new reporting requirements should only apply to bonds being issued after organizations became aware of the IRS intent in this regard.

Conclusion

We fully appreciate the magnitude of the challenge you have undertaken, and are eager to work with you in making the final product the best it can be to achieve the three stated goals.

Sincerely,

Bruce McPherson

Bruce McPherson
President and CEO

From:	Roxie DeAngelis
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	NAUH Form 990 Comment Letter
Date:	Wednesday, September 12, 2007 9:42:06 AM
Attachments:	IRS Form 990 Comment Letter.pdf

Re: Redesigned Form 990

Please see the attached National Association of Urban Hospitals comment letter regarding Proposed Form 990 and Schedule H.

If you have any questions or concerns, please do not hesitate to contact us.

Sincerely,

Roxie DeAngelis

--
National Association of Urban Hospitals
Phone: (703) 444-0989
Fax: (703) 444-3029
www.nauh.org

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

September 12, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

Subject: Comments on Proposed Form 990 and Schedule H

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our views on the proposed Form 990 and Schedule H.

NAUH supports the concept of holding hospitals to a reasonable community benefit standard in exchange for their tax-exempt status. We do have a few concerns, however, about the manner in which the Internal Revenue Service (IRS) proposes evaluating hospitals to ensure that they truly deserve their non-profit status, and we outline those concerns below.

Bad Debt Should be Considered a Community Benefit

NAUH strongly believes that hospitals' bad debt should be considered a community benefit.

In most of the business world, bad debt consists of bills that customers are able to pay but refuse to pay. In the hospital industry, however, the vast majority of bad debt consists of bills that customers – patients – truly are unable to pay. The Congressional Budget Office (CBO) agrees, noting in its 2006 report *Nonprofit Hospitals and the Provision of Community Benefits* that two separate studies show that "the great majority of bad debt was attributable to patients with incomes below 200% of the federal poverty line." The CBO also concluded that its findings "support the validity of the use of uncompensated care [bad debt and charity care] as a measure of community benefit."

The patients who are responsible for most of hospitals' bad debt typically are medically indigent: employed but at low-paying jobs with no health insurance, living from paycheck to paycheck without the means to afford insurance on their own. They are working-class and middle-class Americans, ineligible for Medicaid yet unable to afford health insurance without their employers' assistance. The majority of these people do not have the means to pay their hospital bills, and stories about hospitals' attempts to collect such debts occasionally become headline news, evoking public outrage and inspiring critics, including many public officials, to urge hospitals to be less aggressive in their efforts to collect payments from such individuals.

When patients present themselves for care, hospitals do not always receive enough information to determine immediately whether they should be recipients of charity care – a possible designation for many patients whose bills ultimately become bad debt. Many such patients do not want to complete forms and do not want to be stigmatized by the notion that they are recipients of charity care. These patients often understand that legally, hospitals cannot turn them away in times of medical emergency. Some might even be eligible for

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Medicaid or their state's children's health insurance program but will not cooperate with hospital personnel trying to enroll them. Similarly, hospitals know that some of their patients cannot afford to pay for certain aspects of their care – and many of these patients know that the hospitals know. Non-profit hospitals consistently provide this care anyway. According to current accounting standards, hospitals are required to classify patients when they present for care, so learning afterward that a patient does not have the means to pay for care or will not cooperate with efforts to enroll them in Medicaid or a state children's health insurance program cannot lead to their reclassification as recipients of charity care; their unpaid bills for this care must be written off as bad debt.

Medicare actually fosters this approach, requiring hospitals to classify some elderly patients as bad debt immediately if they intend to seek Medicare bad debt reimbursement. Many Medicare patients are dually eligible for government assistance with their health care – that is, they are eligible both for Medicare and for Medicaid – and cannot afford to pay their co-payments and deductibles. Such lost income is clearly charity care in the sense that the patients cannot afford the payments, and it should be counted toward hospitals' community benefit. Medicare, however, requires it to be classified as bad debt – even though hospitals know, from the start, that these patients cannot pay and that Medicare will reimburse them for only 70 percent of this bad debt.

NAUH recognizes that for-profit hospitals also provide charity care and incur bad debt, but there is a fundamental and significant difference between the efforts of non-profit and for-profit hospitals. For-profit hospitals routinely limit their enterprises to communities with the highest proportions of insured patients and routinely close hospitals and abandon communities that fall upon hard times. Mission-driven non-profit hospitals, on the other hand, make it a practice to serve low-income and medically underserved Americans; to remain in those communities during the hardest of times; and to find ways to deliver care even though they will have to provide millions in charity care, and incur millions in bad debt, to do so. There is no rush within the for-profit hospital industry to serve low-income communities – no rush to establish new hospitals in places like Detroit and Newark and Camden and Washington, D.C. Instead, for-profit corporations gladly leave such endeavors to their non-profit counterparts. By virtue of their business strategies, for-profit hospitals, even though they deliver care that results in bad debt, conduct their business in a manner that manages to limit their exposure to potential bad debt. Non-profit hospitals, on the other hand, consistently locate – and remain – in areas where human needs are greatest. Unlike for-profit hospitals, which grudgingly acknowledge that they will not be paid for all the care they provide, non-profit hospitals consistently, and at great financial risk to their institutions, reach out to the underserved, fully aware that many of those underserved people will not be able to pay for their care.

Alongside charity care, bad debt serves as the heart of what these mission-driven organizations bring to their communities. Bad debt, like all uncompensated care, is an unmistakable community benefit that we believe should be recognized and acknowledged when considering hospitals' tax-exempt status.

Delay Implementation of the New Schedule H

Regardless of the form that Schedule H ultimately takes, NAUH urges the IRS to delay its implementation until 2010. The reporting requirements will be new, they will be significant, and they will border on onerous. They will require a good deal of time, effort, and investment in technology, and NAUH fears that such quick implementation could lead to well-intended but inaccurate reporting. Implementing these new reporting requirements in 2008 would impose a major burden on all hospitals – especially since the form is not expected to be finalized and made official until mid-2008. Consequently, NAUH urges the IRS to delay the schedule's introduction for two years and give hospitals an opportunity to prepare for this new, major reporting requirement.

Other Selected Concerns

NAUH has other concerns that we would like to bring to the IRS's attention for further consideration and study.

1. Some of the instructions and definitions for Schedule H are, in our view, insufficiently clear. NAUH urges the IRS to work with hospital industry representatives to improve both the form's instructions and its definitions before finalizing the schedule and its supporting documentation.
2. In particular, the instructions accompanying the draft of Schedule H are not clear about how multi-hospital health systems and multi-campus hospitals should report their data. NAUH urges the IRS to allow multi-campus hospitals and multi-hospital health systems to decide on their own whether to report the required data on an aggregated, hospital-wide basis or on an individual campus or hospital basis. Some such institutions aggregate their accounting and some do it separately, and we believe it would be burdensome to compel any of them change their accounting systems for this purpose alone.
3. While NAUH supports the federal government's effort to ensure that hospitals that enjoy tax-exempt status truly deserve that status, we believe the data collected on Schedule H should be used for IRS purposes only – and only when considering the tax-exempt status of individual hospitals. It should not be used for the creation of public policy and therefore should not be aggregated.
4. NAUH urges the IRS to establish firm, quantifiable standards for community benefit, and for non-profit status, before it begins collecting this data. Without such standards, this process could become little more than a burdensome and costly exercise in data collection for data collection's sake.

Conclusion

Across the country, thousands of non-profit hospitals bring enormous benefits to their communities. Many – like those represented by NAUH – serve as safety-net hospitals in communities that no for-profit company would ever even consider serving. By every measure of hospitals' financial well-being, private, non-profit urban safety-net hospitals like those represented by NAUH are in worse financial condition today than any other group of hospitals in the country. Throughout the country, many are closing their doors, unable to maintain their financial health in the face of so much demand for free or undercompensated care. Many are on the brink of insolvency, and NAUH respectfully urges the IRS to consider carefully any steps that may result in pushing these hospitals over that brink.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

* * *

We appreciate your consideration of our views and welcome any questions you may have about them. We also are prepared to work with you, at your request, to address any of the issues we have raised in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director

From:	Scanlon, Colleen
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	CHI Comments
Date:	Tuesday, September 11, 2007 10:55:28 PM
Attachments:	CHI_990_Comments.doc

Please find attached Catholic Health Initiatives' comments on the revised Form 990 and new draft schedules for tax-exempt organizations. We have sent a signed, paper copy by overnight mail, but wanted to provide an electronic copy as well.

Colleen Scanlon, RN, JD
Senior Vice President, Advocacy
Catholic Health Initiatives
PH: 303-383-2693
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CATHOLIC HEALTH INITIATIVES

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September 10, 2007

Mr. Ron Schultz
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

Dear Mr. Schultz:

Catholic Health Initiatives appreciates the opportunity to comment on the redesigned Form 990 and new draft schedules for tax-exempt organizations. Catholic Health Initiatives is a non-profit, faith-based, mission-driven health system that includes 73 hospitals, 42 long-term care, assisted-living and residential units, and two community health service organizations in 19 states.

Catholic Health Initiatives endorses the comments provided by the Catholic Health Association. We have also identified several areas that are problematic for our system and our individual hospitals. We believe some of the information requests create undue administrative burdens, provide misleading information or fail to reflect the realities of our environment.

We encourage the Internal Revenue Service to make several changes or clarifications to the form and schedules.

FORM 990

Filing Requirement

We encourage the IRS to clarify that Form 990 may be filed by a corporation and does not need to be filed separately for each entity under a corporation.

Part I, Line 7

In the context of a health care system like Catholic Health Initiatives, this question will result in misleading responses. The question asks for the total compensation of the highest paid individual listed in Part II, Section A. The total includes compensation from the filing organization as well as compensation from any related organizations.

At each of our hospitals, we have an ex-officio board member whose title is that of Senior Vice President of Operations. This individual is employed and compensated solely by the parent company, Catholic Health Initiatives (i.e., a related organization). This same person may serve on up to ten different hospital boards. On many of our hospitals' tax returns, this individual's compensation would be reported on Line 7. Thus, a person who is not even employed by the filing organization would be listed on Line 7. Since Part I is supposed to be a "snapshot" of the filing organization, it is very misleading to have a compensation number on Line 7 that does not come

from the actual filing organization. The question asked in Line 7 is unnecessary since the complete information about the compensation is available on the next page in Part II.

We encourage the IRS to remove Line 7 from Part I of Form 990 and rely instead on Part II for more accurate and complete information.

Part II, Section B, Line 5 e-f

The purpose of this question is to determine whether any officer, board members, key employee, etc. also serves in a similar role for an organization with which the filing organization does business. This question is very problematic for a health care system like Catholic Health Initiatives because very often there are individuals who serve in these roles for multiple, related organizations.

In a large health care system there will be extensive relationships and business transactions between related organizations. That is, in fact, exactly why health care systems are successful – system corporations provide many back office functions efficiently and cost effectively for member hospitals. To ask a hospital to disclose all the services provided by its related organizations simply because they share a board member does not seem reasonable and it is likely impossible for a hospital to identify all those transactions.

We encourage the IRS to reword Part II, Section B, Lines 5 e-f to exclude relationships and business transactions between affiliated organizations.

Part II, Section B, Line 8

(See detailed comments and recommendations under Schedule J below)

Part III, Line 3b

This question requires an organization to report the number of transactions the organization reviewed under its conflict of interest policy. This number would be very difficult to quantify. At each of our hospital's board meetings there are likely several transactions that require that the conflict of interest policies be reviewed. But the numbers are not tracked and a review of board minutes would be unlikely to lead to the number.

We are uncertain as to what conclusions would be drawn from the reporting of a number. Would a high number mean the organization was very diligent and reviews every single transaction that remotely raises a conflict issue, or would a high number mean the organization was awash in conflicts? Would a low number mean the board was lax or would it mean that the board was so well educated and conscientious that they never entered into a conflict transaction?

We encourage the IRS to remove Part III, Line 3b from Form 990 to avoid providing information that would be subject to misinterpretation.

Part III, Line 8

This question asks whether an independent accountant provides services for a compilation, review or audit of the organization's financial statements. We are unclear how hospitals and other organizations in a health care system would respond to this question.

In our health care system, the financial data from all our hospitals and other organizations are consolidated into one set of financial statements. These consolidated financial statements are then audited by an independent accounting firm. However, individual hospitals in the system are not audited separately. How should an individual hospital in our system respond to this question on its tax return? On a consolidated basis, its financial data is audited, but it does not have its own audit report to show for it.

We encourage the IRS to add a box in Part III, Line 8 for inclusion in a consolidated audit by an independent accountant, or an instruction that inclusion in a consolidated audit means that the corporation's financial statements were audited by an independent accountant.

Part III, Line 10

This question asks whether the governing body of the organization reviews the Form 990 before it is filed. For hospitals and other organizations in Catholic Health Initiatives, trying to respond affirmatively to this question would be administratively impossible. There is no legal requirement that an organization's governing body review the Form 990 before it is filed, but a "no" response would cause a negative perception.

Catholic Health Initiatives prepares the Form 990s in-house for cost efficiency and to assist our hospitals. The governing bodies of our organizations only meet at certain times during the year. For an organization of our size, where we prepare and file close to 120 Form 990s, many of which, by necessity, are filed at or near deadline, it would be hugely punitive to expect each governing body to review the return before it is filed.

In most cases, the governing body will have already had involvement in any material information that is found on the Form 990. For example, the governing body will most likely have approved the budget prior to the beginning of the fiscal year and will have reviewed the financial statements after year end. Thus, the governing body will already be familiar with any financial information that is found on the Form 990. Furthermore, the governing body plays a significant role in setting the compensation amounts for the officers and key employees of the organization.

There is little material information on the Form 990 that it would be imperative for the governing body to be made aware of before the return is filed. It is not necessary to ask this question. The filing of Form 990 is a management issue, not a governance issue. The filing is already subject to penalty of perjury, which should be sufficient.

We encourage the IRS to remove Part III, Line 10 from Form 990.

Part III, Line 11
This question asks an organization to indicate where documents are made available to the public. One of the listed documents, a corporation's Articles of Incorporation, is already made public on the Secretary of State's website so there is no need to ask about the public availability of this information.

We encourage the IRS to remove from the list under Part III, Line 11 items that are already publicly available, like corporate documents.

SCHEDULE H -- HOSPITALS

Part I Community Benefit Report
The health of a community is impacted by more than the medical services provided to sick or injured individuals. It is as important to prevent these illnesses and injuries. Social and environmental factors are strong determinants of health for vulnerable populations. Our hospitals engage in community building programs that seek to eliminate some of the root causes of illness and disease. These activities should be reflected in Schedule H.

According to the World Health Organization, "A person's health is influenced by the conditions in which she or he lives. Social and economic conditions – such as poverty, social exclusion, unemployment and poor housing – strongly influence health."

Unhealthy environments, including poor housing, few opportunities for employment, unsafe schools and streets, and lack of access to healthy foods and physical activity, lead to adverse behaviors that increase the risk of disease and disability. Nearly 50% of annual deaths in the United States, and the impaired quality of life that precedes them, are attributable to external environmental or behavioral factors.

To improve the health of our communities, our hospitals have engaged in a variety of community building projects, including: nutrition counseling, domestic violence crisis centers, gang prevention, development of life skills for troubled youth, affordable housing development; availability of child care services, safe and accessible playgrounds, and training and employment for vulnerable populations.

For example, in London, Kentucky, childhood obesity is a significant community health problem with 31% of kindergarteners being obese. Obesity, in turn, leads to a lifetime of medical problems. Marymount Medical Center worked with a community coalition to educate parents of elementary school children and school nutrition workers about ways to help students improve nutrition and be more physically active.

In Pierre, South Dakota, St. Mary's Healthcare Center learned that 42% of students in grades 6, 7 9 and 11 had been victims of physical violence during the past two years. St. Mary's established a Child Advocacy Center in cooperation with law enforcement, tribal units and local agencies to provide services that were not previously available without a 3-4 hour drive.

These are just several examples of community building activities that are part of community health and community benefit.

We encourage the IRS to add a line titled, "Community Building Activities," in between lines 9 and 10 of Part I of Schedule H.

Part II Billing and Collections

The information requested in Part II would be very difficult for hospitals to collect. Our hospitals do not track "uninsured" as a category of patient but rather use a larger category of "self pay" that includes uninsured patients but many others as well.

"Self pay" can include patients whose bill is being paid by worker's compensation, who have been injured in a car accident and whose bill is being paid by indemnity insurance, or who are paying through a cafeteria plan or health savings account. Sorting data to satisfy the chart's requirements would be immensely burdensome.

In addition, discounts provided to insurers are frequently confidential and proprietary and cannot be disclosed under agreements with insurance companies. If a single payor in a community is predominant, which is increasingly the case in many areas, the dominant payor's discount can be imputed from aggregate discount information.

Finally, neither the IRS nor Congress has ever stated that a hospital's billing and collection and discount practices are a basis for tax-exemption. This information is not related to the community benefit standard.

We encourage the IRS to delete Part II of Schedule H.

SCHEDULE J - SUPPLEMENTAL COMPENSATION INFORMATION

Nontaxable Expense Reimbursement and Nontaxable Benefits

Schedule J is intended to capture supplemental compensation for certain officers, trustees, key employees and highly compensated employees. However, the schedule requests information that is not compensation to the individual and its inclusion provides misleading and inaccurate information on an individual's compensation.

It is not equitable to categorize non-taxable expense reimbursement as benefits to an employee. For example, paying for business travel does not provide an economic benefit to an employee. Anyone who has had to travel extensively for employment purposes knows that the travel is burdensome and hardly considered a benefit. Many of the individuals who would be listed on Schedule J are required to travel extensively for business purposes. It is grossly misleading to report reimbursed business expenses as compensation for these individuals.

Furthermore, the amounts listed would not be consistent from organization to organization, or person to person. If one used a personal credit card, it would have to be reported. If that same person used a company credit card, the expense would not be reported.

The reporting of nontaxable benefits is also problematic. The instructions seem to require reporting of de minimis fringe benefits, which by definition under the Internal Revenue Code are "so small as to make accounting for it unreasonable or administratively impracticable." Unnecessary time and resources would be devoted to identifying whether such things as providing coffee and creamer are reportable benefits. De minimis fringe benefits should not be considered part of individual compensation.

We encourage the IRS to eliminate Column E, Nontaxable Expense Reimbursements, from Schedule J.

We encourage the IRS to revise instructions to clearly exclude de minimis fringe benefits from reporting requirements for Column D, Nontaxable Benefits.

Deferred Compensation

The double reporting of deferred compensation both in the year it is originally deferred and again in the year it is actually paid distorts the true compensation that an individual receives. This double reporting came about over concerns that an organization would defer the excess compensation to the future when the individual was no longer employed by the organization so it would not need to be reported.

Beginning with the 2005 Form 990, compensation paid to former officers had to be reported. It is no longer necessary to require organizations to report the deferred compensation twice. It should not need to be reported in the year it is accrued.

Furthermore, in many cases, the deferred compensation faces a substantial risk of forfeiture. With this risk of forfeiture, the deferred compensation should not be considered compensation until it is actually paid. By reporting deferred compensation in the year it is accrued, misleading information may be provided about the compensation individuals are actually paid.

We encourage the IRS to eliminate double reporting of deferred compensation and only require reporting in the year it which the compensation is actually paid.

SCHEDULE K – SUPPLEMENTAL INFORMATION ON TAX EXEMPT BONDS

Catholic Health Initiatives was formed by the combination of four Catholic health systems. Various nonprofit and for-profit corporations and other organizations that own and operate health care facilities and provide health care services are controlled or owned by or affiliated with Catholic Health Initiatives. These organizations, with Catholic Health Initiatives, are part of CHI Credit Group.

The CHI Credit Group is legally structured under a corporate debenture model in which Catholic Health Initiatives, the parent corporation, is the sole obligor on all debt issued through the Capital Obligation Document. Currently CHI has 42 bond issues outstanding.

Schedule K poses a significant administrative burden for us, particularly in the year of adoption, given the number and complexity of our bond issues covering a wide range of projects at multiple organizations. In addition, any data required for refunded bonds originally issued before Catholic Health Initiative was formed, could be very difficult or perhaps impossible to obtain.

We believe that any changes in reporting requirements should be prospective since it is not feasible to go back multiple years to collect information that we did not know would be needed at the time of the bond issue.

Due to the scope of required information, implementation of Schedule K should be delayed until 2010 to allow organizations to undertake the analyses needed to prepare for the submission of additional requested information. In addition, clarified instructions for Schedule K are needed to adequately define the scope of required information. For example, if a currently outstanding bond issue refunded a prior issue, it is not clear whether the "Description of Purpose" needs to include the assets financed in the original issue.

We encourage the IRS to provide a "grandfather" provision under which information is required to be reported only for bonds issued after the date the redesigned Form 990 becomes effective.

We encourage the IRS to delay implementation of Schedule K, along with all of the Form 990, until 2010 to allow organizations time to prepare for reporting of new information based on clarified instructions.

We also offer the following comments on specific sections of Schedule K:

Part I

Much of the requested information is already provided and filed in the Form 8038 (Information Return for Tax-Exempt Private Activity Bond Issues). Having organizations list the information again is redundant and time consuming.

Questions "f" and "g" are particularly burdensome. Catholic Health Initiatives' bond issues involve large principal amounts that fund multiple projects, including buildings and equipment. It would be very difficult to provide each "placed in service date" and could be impossible to provide this information for refunded bond issues.

Part III

Organizations should only have to report those contracts that result in private use. A contract's falling outside the safe harbors described in Rev. Proc. 97-13 or 97-14 does not necessarily indicate that the contract creates private use. Instructions should require organizations to report private use on those contracts exceeding a stated de minimus percentage.

Part IV

The information requested in Part IV is reasonably obtainable as it applies only to the current year. However, the instructions should clarify what is meant by a "formal selection process". Any clarification should permit organizations to rely on selections that involved advice of bond counsel and/or a qualified underwriter with a reasonable review of qualifications. It should be noted that relationships with third parties involved in financings are often retained for several years without employing an annual "formal selection process".

SCHEDULE R – RELATED ORGANIZATIONS

Transactions with Related Organizations and Noncharitable Exempt Organizations

Part V of Schedule R is extremely burdensome for multi-hospitals systems and their hospitals. We understand that certain questions on Schedule R are in response to provisions of the Pension Protection Act, but the requested information in Part V, particularly Line 2, go beyond the intent of Congress and are not necessary.

Under the Pension Protection Act, a controlling organization has to disclose any transactions it had with any entities under its control. This new disclosure requirement is already somewhat onerous, but it is at least manageable. Schedule R expands this requirement to any and all related organizations – not just controlling organizations.

For Catholic Health Initiatives and its hospitals, this expansion would create a mammoth requirement. All of our tax exempt organizations would have to list on their Form 990 more than 180 related organizations and determine if there were any transactions between them and any of these 180 related organizations. Gathering this information for each return would be tremendously time-consuming for the system and its individual hospitals.

In accordance with the Pension Protection Act, the information on transactions between related 501(c)(3) organizations should be limited to transfers that could result in unrelated business income tax under the controlled entity rule of Section 512(b)(13). Other transactions between related 501(c)(3) organizations do not raise compliance, exemption, tax or other concerns and should not need to be reported.

We encourage the IRS to limit the disclosure requirements of Part V of Schedule R to transactions between controlling organizations and any controlled entities.

Thank you for providing us with the opportunity to comment. Please contact Paul Neumann, General Counsel, at 303-383-2678 or for additional information on any of the issues we have raised.

Sincerely

Kevin E. Lofton
President and Chief Executive Officer

From:	Anne McLeod
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comment Letter on Form 990 and Schedules
Date:	Tuesday, September 11, 2007 6:07:24 PM
Attachments:	IRS Comment Letter on Form 990 and Sched H.doc

Anne M. McLeod
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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

September 11, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

By Electronic Filing

Re: Comments on Draft Redesigned Form 990 and Schedules, Including Schedule H

On behalf of the California Hospital Association (CHA), thank you for the opportunity to comment on the draft redesigned Form 990 and new draft schedules, including Schedule H. CHA is a nonprofit organization dedicated to representing the interests of hospitals and health systems in California. CHA represents more than 400 hospital and health system members, including general acute-care hospitals, children's hospitals, rural hospitals, psychiatric hospitals, academic medical centers, county hospitals, investor-owned hospitals and multi-hospital health systems. These hospitals furnish vital health care services to millions of our state's citizens. CHA also represents more than 100 Executive, Associate, and Personal members. CHA provides its members with state and federal representation in the legislative, judicial and regulatory arenas, in an effort to improve health care quality, access and coverage; promote health care reform and integration; achieve adequate health care funding; improve and update laws and regulations; and maintain public trust in health care.

We appreciate the work that the IRS has put into the new form and schedules, and its openness to comments from the hospital community. In recognition of the robust effort by the IRS to improve reporting by tax-exempt organizations, it should be no surprise that tax-exempt hospitals have concerns about the content and structure of the draft forms and schedules.

Our concerns are summarized as follows:

- The filing deadline is too short and should be extended to at least tax year 2010 for Form 990 and all schedules.
- Schedule H should be redesigned to more accurately reflect a comprehensive assessment of community benefits provided by hospitals while eliminating unnecessary and burdensome questions unrelated to community benefit.
- Schedule K carries a burden similar to a full-scale audit that could cost California's tax-exempt hospitals hundreds of thousands of dollars.

Given the number of concerns raised about the draft redesigned Form 990 and schedules, it is impossible to capture all the issues in this comment letter. However, we have identified many of the most problematic concerns to assist the IRS in making the necessary revisions. Further, because of the significant revisions that must be made, CHA believes it is important for tax-exempt

hospitals to be given an opportunity to review the revised set of forms and schedules, with another 90-day review period following the re-draft. It would be a disservice to the tax-exempt hospital community to undertake the first major overhaul of the Form 990 in 25 years without adequate time for review and input. A rushed implementation schedule will not result in the desired transparency, and will be costly to tax-exempt hospitals and the IRS.

Core Form 990

- Group returns should not be eliminated as this would result in a significant burden (Part I).
- Information about individual compensation provides information of limited use to the IRS and could be misleading to viewers when read outside of a comprehensive context (Part I).
- Fundraising expenses as a percentage of total contributions and grants does not provide helpful information about an organization's operations (Part I).
- A clearer definition of "substantial part" is needed in reference to determining how many "key employees" a hospital may have (Part II).
- Personal information, including home address, should not be collected by the IRS (Part II, Section A).
- Information on former directors, trustees, officers, key employees or highest compensated employees should look to current year only (Part II, Section A).
- The collection and maintenance of documents required to respond to questions in Part II, Section B will create excessive new burdens.
- The IRS should clarify the request in Part II, Section B, Line 9 to address the extent to which an organization is required to seek information regarding such compensation arrangements.
- Part III should be clarified to ensure that changes to articles of incorporation and bylaws is requested on Line 2. Further, Line 10 places an overly burdensome request on a hospital's governing body to review the Form 990 before filing.
- The instructions for Part IV, Line 1d are confusing and require clarification regarding contributions received from related organizations.
- The business codes on 990-T are not broad enough to reflect accurately program service revenue (Part IV, Lines 2a – 2g).
- A reference between Lines 11a and 1c would be helpful, related to reporting contributions from fundraising events.
- The instructions for Part VII, Line 6a, should be clarified as to whether this question is intended to encompass bond financing where the 501(c)(3) organization is not the issuer of the bonds but rather the borrower of the proceeds of government-issued bonds.
- To the extent the IRS intends to develop sample written policies for reviewing the organization's investments and safeguarding its exempt status with respect to transactions and arrangements with related organizations, the IRS should solicit input from members of the tax-exempt sector with respect to the content and form of such written policies.
- The question on Lines 3a – 3c of Part IX should be moved to Part I of the form. Moreover, organizations should be allowed as much additional space as necessary to describe more than three key program services.

Schedule A

- Part I, Line 11f should allow for an IRS determination or "a written opinion of counsel."
- Part I, Line 11h, column (vii) should be revised to include the value of non-monetary support.

Schedule C

- Instead of asking for precise amounts related to political campaign and lobbying activities, the IRS should ask for a range of hours, number of employees or other proxies for amounts that would provide the IRS with useful information while making the category less burdensome.

Schedule D

- The listing of securities individually in Parts I and III is extremely burdensome.
- Disclosing the text of footnotes relating to uncertain tax positions in isolation could be misleading. Therefore, organizations should be given the opportunity to explain such footnotes or to attach their entire financial statement (Part VII).
- The reporting associated with Endowment funds in Part XII seems to outweigh the usefulness of this information. Moreover, the five-year retrospective period should be reduced or eliminated.

Schedule F

- Schedule F requires the separate reporting of grants outside the U.S. from domestic organizations and individuals. Many hospitals and health care organizations do not maintain records and reports in a format that would permit them to gather all of the information required to be reported on the schedule. The required amount of recordkeeping could discourage organizations from making grants, even small ones, to foreign organizations or individuals. In addition, because of safety and security concerns, Schedule F should not be open to public disclosure.

Schedule G

- The IRS should clarify how tax-exempt hospitals should report on fundraising activities by related entities, which is a common activity within a hospital or health system.

Schedule H

The new Hospital Schedule H should allow our hospitals to report the great diversity of community benefits our members provide, and it should not redefine community benefit in a manner that permits others to determine what programs and services are most appropriate for our communities.

Based on our initial reviews, we have three primary concerns with Schedule H that we are asking the IRS to address:

- The filing deadline for Schedule H is far too short and should be extended;
- The full value of hospital community benefit is not included in Schedule H and should be; and
- The IRS is requesting information that is unrelated to community benefit and will not be meaningful to the public. It should be removed from the form.

IMPLEMENTATION SHOULD BE DELAYED UNTIL 2010 TO ACCOMMODATE THE DELAY THE IRS ANTICIPATES IN ISSUING INSTRUCTIONS, AS WELL AS THE NEED TO ADJUST OR CREATE SYSTEMS TO CAPTURE THE REQUIRED FINANCIAL INFORMATION.

We are committed to transparency. However, the burden of having to reconfigure financial and data record-keeping systems in time to begin capturing the substantial amount of data required just for the Part I Community Benefit Report by January 1, 2008, is itself a daunting task. It is made virtually impossible by the fact that the instructions, definitions and worksheets needed to collect that data are not expected to be finalized until mid-2008. To require hospitals to overhaul financial and data recordkeeping systems before the definitions, line item instructions and worksheets for making the calculations required for Schedule H are completed is unreasonably costly and disruptive.

Given the number of questions and concerns about Schedule H that have surfaced, we would urge the IRS to consider providing a second draft in 2008 and another review period toward the goal of finalizing the schedule in December 31, 2008. That would give hospitals sufficient time to revise their financial and data record-keeping systems in order to track and capture new information that will need to be reported.

THE FULL VALUE OF BENEFITS HOSPITALS PROVIDE SHOULD BE INCLUDED IN SCHEDULE H.

Hospitals qualify for the charitable purpose of promoting health by meeting the community benefit standard. The community benefit standard permits us to tailor our programs and services to the needs of our individual community. Among those needs is providing care for elderly Medicare patients and low-income patients who may not be able to afford the costs of their care. Yet our members provide their care proudly, and the costs absorbed in doing so should be reflected as a community benefit on Schedule H.

- **Medicare underpayments are community benefit.**
  Part I "Community Benefit Report" in draft Schedule H allows hospitals to report and receive community benefit credit for Medicaid and other government program underpayments, but not for Medicare underpayments. We believe Medicare underpayments should be included. California hospitals report more than $3.2 billion in Medicare underpayments that would not be captured on the proposed Schedule H.

  Serving Medicare patients is part of the community benefit standard. Medicare, like Medicaid, does not pay the full cost of patient care. As a result, our hospital and communities must absorb and compensate for these underpayments. Currently, Medicare reim-

burses hospitals 92 cents for every dollar spent on care. The Medicare Payment Advisory Commission (MedPAC) in its March 2007 report to Congress cautioned that the situation will get even worse, with margins reaching a 10-year low at *negative* 5.4 percent. Moreover, an increasing number of Medicare beneficiaries are also low-income. More than 46 percent of Medicare spending is for beneficiaries whose income is below 200 percent of the federal poverty level.

- **The cost of patient bad debt is a community benefit.**
  As currently drafted, Schedule H does not count patient-care bad-debt expenses as a community benefit. We know that a significant majority of bad debt is attributable to low-income patients, who for many reasons decline to complete the forms required to establish eligibility for charity programs. California hospitals report more than $1 billion in bad-debt costs that should be accounted for on Schedule H.

  A 2006 Congressional Budget Office report cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200 percent of the federal poverty level." The fact is that despite our best efforts, many of our patients still do not identify themselves as in need of financial assistance. It is important to us and to our community that the full cost of serving our community — including the cost of serving patients who need help paying their bills but fail to ask for it — be recognized and counted as community benefit.

SCHEDULE H NEEDS TO BE STREAMLINED TO ELIMINATE QUESTIONS THAT ARE BURDENSOME AND CONFUSING, AND FAIL TO PROVIDE MEANINGFUL INFORMATION TO THE COMMUNITY.

The proposed chart on Schedule H, Part II relating to billing should be eliminated. It has no bearing on determining whether a hospital is meeting the community benefit standard, and it should not be used to create new reporting standards.

Relevant information is already provided in other parts of the Form 990. For example, detailed information on charity care will be provided in Part I of Schedule H. Information related to a hospital's revenues and Medicare and Medicaid payments will be included in Form 990.

Beyond that, the chart's added layers of requests for information are burdensome and will require extra staff work to provide. Some of the information requested is competitively sensitive. The chart displays information in a form that will confuse, not inform, the public.

If the IRS requires more information on our charity care policies and practices, or the way in which we support other community benefit activities and programs, it should ask those questions instead of creating new reporting obligations that will be burdensome and will confuse our communities instead of providing them with the information they need to determine whether we are serving their needs.

We recognize that there are other concerns about Schedule H, Form 990 and many other schedules. We urge you to work with the hospital community to identify and resolve those issues before asking us to file a new Form 990 or any of its schedules.

Schedule J

- Further clarification is required to determine the individuals that should be listed on this form (see comments on Core Form).
- The IRS should take this opportunity to eliminate the double reporting of nonqualified compensation that exists on the draft redesigned form, as well as the current Form 990. Clarification is also required on how compensations should be reported if the organization is reporting on an accrual basis.
- The IRS should allow for de minimis fringe benefits to be excluded from reporting (Line 1, column (D)).
- Schedule J should not include reporting of amounts related to reimbursement of expenses as it creates a misleading view, especially in disclosure of compensation amounts.

Schedule K

- The scope if information required for reportable tax-exempt bonds is similar to the burden associated with a full scale audit and will cost hundreds of thousands of dollars to our member hospitals.
- Much of the information requested on this schedule is already available through form 8038, Information Return for Tax-Exempt Private Activity Bond Issues, which is filed when bonds are issued.
- The instructions for Part II should reduce the burden associated with reporting information on bond proceeds by limiting how far an organization must go back when a bond is used to refund a prior issue.
- Part III instructions related to private use of tax-exempt bonds should clarify that aggregate reporting for private business use is contemplated and the IRS should consider permitting organizations to report private business use as not exceeding a stated de minimis percentage.
- The instructions for Part IV on compensation of third parties who provide services related to bond issuances should be clarified as to what is meant by a “formal selection process” and should permit organizations to rely on selections that involve advice of bond counsel and/or a qualified underwriter with a reasonable review of qualifications.

Schedule I

- The threshold for reporting grants and other assistance to individuals in the U.S. is too low at $5,000.

Schedule L

- This schedule should reference “highest compensated employees” from Part II of the core form. The use of this description is unnecessarily confusing in this context.

Schedule M

- The threshold for completing this schedule of non-cash contributions should be increased to at least $20,000.

Schedule N

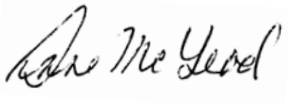
- The IRS should clarify if transfers of assets to a wholly owned limited liability company that is disregarded as separate from the tax-exempt filing organization need to be reported. In addition, clarity is needed as to whether transfers for "full and adequate consideration" that are excluded from the definition of "substantial contraction" still need to be reported as a disposition of net assets.

Schedule R

- The reporting required under Part V — Transactions with Related Organizations — is extremely burdensome, especially for multi-hospital systems. Flexibility should be included in the instructions when reporting transfers, gifts and grants between related 501(c)(3) organizations.
- Tax-exempt organizations within a health system typically have numerous arrangements involving the performance of services, leasing or sharing of facilities, equipment or employees, cost reimbursement etc. There could be hundreds of transactions reportable under this Part V. While certain questions on this schedule are in response to Section 1205 of the Pension Protection Act, the information on transactions between related 501(c)(3) organizations should exclude transactions that do not raise compliance, exemption, tax or other concerns and should not be reported.

CHA appreciates the opportunity to submit comments and we would like to thank you for your leadership in recognizing the importance of improving the core form and schedules. On behalf of our member hospitals, we particularly encourage you to consider our recommendations on improving Schedule H to more effectively capture a comprehensive assessment of hospital community benefit reporting. Please contact me at (916) 552-7536 or amcleod@calhospital.org, with questions or for further assistance.

Sincerely,



Anne McLeod
Vice President – Reimbursement and Economic Analysis

From:	Harry A. Bold
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Emailing: IRS Form 990 Letter
Date:	Tuesday, September 11, 2007 5:56:33 PM
Attachments:	IRS Form 990 Letter.doc

<<IRS Form 990 Letter.doc>>
The message is ready to be sent with the following file or link attachments:

IRS Form 990 Letter

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.

Big Sandy Medical Center
PO Box 530
Big Sandy, MT 59520

September 11, 2007

Internal Revenue Service
Form 990 redesign, Se: T: EO
111 Constitution Avenue, NW
Washington, D.C. 20224

RE: Comments on Draft Redesign Form 990 and Schedules

Please allow this letter to serve as notice that our Critical Access Hospital (CAH) finds the requirements of the proposed changes to Form 990 excessive and burdensome. Big Sandy Medical Center is an 8 bed CAH and has a 22 bed Skilled Nursing Home attached and we are owned and operated by a Community Board of Directors elected by the Community. All Board meetings are open to the public and each year a Public Annual Meeting is held for the community where operational and financial reports are reviewed with the public as well as the hospital's community benefit report and there is an election of several Board Members.

The proposed changes to the Form 990 would harness resources that are scarce in the business office by requiring software and staff time to compile information that would be needed on the proposed Form 990. Cost for software and staff time would be in the neighborhood of over $10,000. This past year our CAH did not even have a profit, thus the burden of these additional costs would add to either the property tax levy on the tax payers or it would result in cutting of services in other areas of the hospital. In our case and many other rural isolated hospitals such as ours, the community benefit of **access to health care is a priority!**

The community lacks quality good paying jobs, thus the reason the bad debt costs at this CAH continues to rise. Low income, uninsured and underinsured patients are the prime reasons for an ever increasing amount of bad debt each year. In our view bad debt and Medicare unpaid costs should be considered in all CAH's community benefit reports. With the ever increasing amount of Medicare Advantage patients who fall outside of the calculations of the annual cost report, Medicare unpaid charges are on the rise. Combined with other costs that Medicare does not allow, this CAH does not receive 101 percent of cost from Medicare.

The request on the proposed Form 990 requiring pricing information is not relevant. This would only allow insurers to glean this information to use against CAH's in reducing payments to bolster their bottom line.

In closing, I would strongly encourage the IRS to exempt Critical Access Hospitals from the proposed changes to the Form 990. The first and utmost benefit for communities that have a CAH is access to health care. If the burden becomes too great and the costs too excessive, the smallest and most vulnerable CAH's could be force to close. Nobody wants to see a hospital close due to federal regulations. I encourage the Internal Revenue Service to exclude CAH's from the requirements suggested in the proposed Form 990.

Please feel free to contact us if you have any questions or concerns.

Sincerely,

Harry Bold, MSA
Administrator of Big Sandy Medical Center

From:	Mike Walsh
To:	*TE/GE-EO-F990-Revision;
CC:	"Bob Olsen"; "Tony L. Pfaff";
Subject:	
Date:	Tuesday, September 11, 2007 3:43:35 PM
Attachments:	

September 11, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

I appreciate the opportunity to submit comments on the draft redesigned Form 990.

Powell County Medical Center is a 19 bed Critical Access Hospital with a 16 bed Skilled Nursing Facility operated in a combined facility model. Powell County Medical Center is a 501-c-3 operating entity for the combined operations, run by a community Board of Directors.

Powell County Medical Center provides annual community benefit reports as part of our annual BOD activities. Our community benefit reports provide the amount of detail which is practical for an organization of our size. We do not use the VHA or CHA programs because of their respective costs and lack of staff to complete the extensive data requirements. With a community centered Board of Directors transparency is really not an issue for our facility.

It is always difficult to make a “one size fits all” model as a solution especially pertaining to hospitals of varied sizes. The critical access hospital program was designed to maintain access in rural and frontier parts of the United States. Critical Access Hospitals like Powell County Medical Center struggle with cash flow and because of our environment probably are some of the most transparent hospitals in the United States. Therefore my areas of concern are identified by the following.

Probable Impacts of Proposed Form 990 on Powell County Medical Center

- The proposed reporting requirements would impose an unreasonable burden on PCMC staff and financial resources to comply at the stated level.
- Schedule H which would require PCMC to quantify the community benefits we currently discuss would cost approximately $6000 in software and a .5 FTE of staff time we do not have available. This is excessive expectation of resource use in this one area when our staff needs to be working on keeping current on CMS regulatory impacts.

To address our concerns, I concur with MHA and recommend that

- CAHs be exempted from the community benefit reporting requirement or be required to report based upon metrics currently tracked which do not require speicialized software to maintain. We use a simple Excel spreadsheet..
- The continued operation of Powell County Medical Center as a Critical Access Hospital should justify our community benefit and exempt Powell County Medical Center from the IRS proposed community benefit reporting.

I agree with the following discussion of additional concerns by MHA:

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

Medicare pays CAH's 101 percent of what it considers cost. However, Medicare excludes a number of costs; as a result, CAH's are really paid only 90-95 percent of cost. Unpaid Medicare costs amount to a subsidy hospitals provide to the Medicare program and are a substantial community benefit.

Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason, decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.

In a 2006 report, the Congressional Budget Office concluded that its study supports using uncompensated care (bad debt and charity care) as a measure of community benefits.

Collecting Pricing Data
The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital. The pricing matrix contained in Schedule H, Part II is unnecessary. Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

The data collected on a historical basis will serve no useful public function. The Form 990 is not an appropriate tool for the public to seek current pricing information about their health care. The Centers for Medicare and Medicaid Services is already working to post price and quality data on the Internet for common services. The effort by the IRS is redundant, at best.

Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

If you would like additional details or have questions please contact me.

Sincerely,

M.A. Walsh

Michael A. Walsh
Chief Executive Officer
Powell County Medical Center
(406) 846-2212, ext. 111

From:	Easterly, Mark
To:	*TE/GE-EO-F990-Revision;
CC:	Zipprich, John; Harper, Patti; Meyer, Donna; Caruthers, Sandy; ODonnell, Margaret; Bane, Ellie; Moreno, Gabriela;
Subject:	CHRISTUS Health Comments on IRS Changes to Form 990
Date:	Tuesday, September 11, 2007 3:23:21 PM
Attachments:	CHRISTUS Health Comment Ltr (09.11.07).pdf

Via Electronic Submission:

Internal Revenue Service
Form 990 Redesign
ATTN: SE:T:EO
1111 Constitution Ave., N.W.
Washington, DC 20224.

On behalf of CHRISTUS Health, please accept the attached comments to the IRS on the proposed redesigned Form 990, schedules and related instructions.

If our organization can be of any assistance, please let me know.

Mark Easterly
Regional General Counsel
CHRISTUS Health
Legal and Governance Services
713-680-4871 office
713-812-6867 fax

CHRISTUS Health Mission: To Extend the Healing Ministry of Jesus Christ

CHRISTUS Health

mark.easterly@christushealth.org
Direct Dial: (713) 680-4871

September 11, 2007

Via Electronic Filing
And Overnight Delivery

Mr. Ron Schultz
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Mr. Schultz:

CHRISTUS Health appreciates the opportunity to comment on the proposed changes to the Internal Revenue Service (IRS) Form 990 and related schedules. With more than 40 hospitals, long term care facilities and senior residential communities, CHRISTUS Health is one of the ten largest Catholic health care systems in the United States. Jointly sponsored by the two religious congregations of the Sisters of Charity of the Incarnate Word in Houston and San Antonio, the Mission of CHRISTUS Health is *To Extend the Healing Ministry of Jesus Christ.*

CHRISTUS supports many of the changes proposed in the new form, not the least of which is added transparency and consistency in the reporting of charity care and community benefits. Under the leadership of our President and CEO, Dr. Tom Royer, in 2006 CHRISTUS re-emphasized a system-wide commitment to transparency with a determination to be an industry leader in making available to the public information about our health system's financial performance, community benefit, clinical quality and patient satisfaction. CHRISTUS Health supports the IRS's decision to follow the Catholic Hospital Association (CHA) framework for reporting charity care and community benefit, which has been adopted by CHRISTUS Health.

In general, our comments focus on the Form 990, the new Schedule H, and Schedule J. Specifically, we would note:

- The IRS should delay implementation of the new Schedule H. CHRISTUS Health believes the timeframe for implementing the new Schedule H is impracticable and should be extended at least to tax year 2010 as recommended by the American Hospital Association, CHA and the Texas Hospital Association. Implementation of Schedule H at a later date will allow the IRS more time to sufficiently address the

many industry concerns as expressed in commentary and response letters. The 2010 timeframe will also permit tax exempt hospitals sufficient time to modify their accounting, data collection and reporting systems as may be required by the new Schedule H.

- What organizations are required to file Schedule H? The IRS should provide further clarification as to exactly which exempt organizations are required to file the new Schedule H. For example, many tax exempt entities are member organizations within a larger nonprofit health system structured as subsidiaries under a tax exempt corporate parent organization. In particular, we would suggest that the IRS clarify that the completion of Schedule H be required only of exempt organizations that directly operate hospitals. In the alternative, Schedule H should incorporate a category to recognize a tax exempt organization that is a parent corporation within a multi-corporation health system structure. Recognizing this reality of modern health care delivery systems, a methodology for system-wide community benefit reporting, similar to the process permitted under the Texas law for nonprofit hospitals, would provide a more complete and total picture of the overall benefits provided within a particular health care system that is comprised of multiple tax exempt organizations.

- Schedule H should include community benefit questions beyond those which are purely quantitative in nature. The definitions of "cash and in-kind contributions to community groups" should be expanded to include the full range of potential contributions that a hospital might make to qualified organizations, such as the donation of hospital facilities for use by other tax exempt health care providers, equipment, supplies, or personnel donated to other exempt organizations, and health care educational programs.

- The definition of community benefit should including "community building" activities, whether or not such activities are directly related to the provision of health care. At line 10 of Part I, a new category of benefit should be added to reflect community building activities performed by exempt hospitals. These programs constitute return to the community, whether or not the activities directly relate to the provision of health care services. Examples include programs designed to improve overall community health, such as providing financial support for low-income housing, job training programs, scholarships, grants, low interest or forgiven loans to community organizations, local and regional relief from natural disasters, and other similar charitable activities.

- Part II on billing and collections should be removed from Schedule H. Part II of Schedule H relating to billing and collection practices should be eliminated, as this information does not relate in any way to an organization's qualification as a tax

exempt entity. Collecting and submitting this information to the IRS will merely increase the administrative burden on hospitals.

- Part III on management companies and joint ventures should be removed. Proposed Part II of Schedule H requires hospitals to provide information concerning any management companies or joint ventures that it is a partner or shareholder thereof, along with the names of officers, directors, trustees or key employees having ownership interests therein. As with the Part II question on billing and collection practices, this section should be removed as the activities inquired about have no relation as to whether an organization provides community benefits and qualifies as a tax exempt entity. The collection and submission of this irrelevant information will only further burden tax exempt hospitals with administrative costs.

- Medicare cost and bad debt should not be included as community benefit categories. CHRISTUS Health supports the CHA position that the unpaid cost of Medicare and bad debt should not be included in the definition of community benefit. This position is also consistent with the definitions of charity care found in the Texas state law for tax exempt hospitals, which CHRISTUS currently complies with and which our organization believes provides an accurate representation of the level of benefit a hospital returns to a community.

- Nontaxable expense reimbursements reporting on Schedule J. We suggest that the proposed requirement to report the nontaxable expense reimbursements to trustees, officers, directors, and other key employees be deleted from Schedule J. Accurately capturing and reporting this information for all individuals listed on Part III of the Form 990 would be impracticable, if not impossible. Further, in the interest of transparency and accurate disclosure, if nontaxable expense reimbursements are reported along with the other direct compensation and benefit information on Schedule J, it could lead to a distortion or misrepresentation of the complete compensation packages for executives and key employees.

To summarize, CHRISTUS Health views the draft redesigned Form 990 and Schedules as an important resource for tax exempt hospitals to share their unique stories with the communities they serve and the public at large. We support all changes that allow hospitals to clearly and uniformly demonstrate benefit activities to the public and communities we serve. We are pleased that the IRS based Schedule H on the CHA standards for reporting charity care and community benefit area. In our opinion, by considering and adopting the comments and suggestions within this letter, the IRS will produce a more understandable and reliable return form that provides users and reviewers with a more accurate portrait of the activities and benefits of tax exempt hospitals.

If our organization can be of any assistance, please let us know.

Sincerely,

Mark Easterly
Regional General Counsel
CHRISTUS Health

WME/

Cc: Donna Meyer
John Zipprich
Margaret O'Donnell
Sandy Caruthers
Patti Harper
Gabriela Moreno

From:	Bob Olsen
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Form 990 Comments
Date:	Tuesday, September 11, 2007 11:02:17 AM
Attachments:	MHA 990 Letter.doc

Please accept the attached letter providing our comments on the proposed modification of the IRS Form 990. Contact me if you have any questions, or need additional information.

Bob Olsen
Vice President
MHA An Assoc of MT Health Care Providers
406.457.8004

September 7, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

MHA, An Association of Montana Health Care Providers, on behalf of our 63 member hospitals, health care systems, networks and other providers of care, appreciates the opportunity to submit comments on the draft redesigned Form 990.

Hospitals have numerous concerns about the proposed modifications and the significant new burdens imposed on hospitals. Our member hospitals and Association staff have worked collaboratively with the American Hospital Association to review the Form 990 and new schedules. We endorse the comments provided by AHA, and ask the IRS to incorporate the recommendations of the AHA in a final regulation.

MHA appreciates the work the IRS has put into its proposed rewrite of the Form 990. We also appreciate the IRS' willingness to discuss these proposed changes with MHA and AHA.

MHA believes it is essential that hospitals voluntarily, publicly and proactively report to their communities the full value of benefits they provide. The MHA Board of Trustees endorsed this principle in a policy statement adopted in August 2006. Since then, staff has worked with member hospitals to fulfill this commitment.

The proposed revisions to the IRS Form 990 would take transparency to a new and significantly higher level. While, we certainly welcome transparency, the IRS proposals raises a number of significant issues that we believe must be addressed before these rules are finalized. Specifically, MHA has identified the following areas of concern.

Impact on Small and Rural Hospitals

- The proposed reporting requirements would impose an unreasonable burden on hospitals, especially critical access hospitals.
- The IRS would substantially change the Form 990 and create 15 new reporting schedules for tax-exempt organizations, including hospitals. MHA staff estimates that Montana hospitals may have to complete as many as eight of these forms.

- Critical access hospitals are least able to comply with the new reporting requirements, especially Schedule H which would require them to quantify the community benefits they provide.
- CAH's have minimal staff in their billing and business offices.
- CAH's do not have staff trained to compile community benefit information, nor do they have the software needed for this task.
- MHA members estimate that compliance would require 120-160 hours a year of staff time. This does not include the time required to install and train staff on how to compile the data.
- The software used by CHA and VHA hospitals to compile community benefit data costs more than $6,000 to purchase. In addition, annual update fees are charged. Only one of Montana's 45 CAH's uses this software currently.

To address our concerns, MHA recommends that

- CAHs be exempted from the community benefit reporting requirement or be required to report based upon a significantly reduced dataset.
- The continued operation of CAHs – providing the only access to health care in frontier communities – should justify their community benefit.
- Instead of quantifying their community benefit, as proposed by the IRS, CAH's could be required to list the community benefits they provide and the direct cost for those activities. This would ensure accountability while also avoiding the extra administrative burden caused by measuring indirect costs, as required on the CHA and VHA software.

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

Medicare pays CAH's 101 percent of what it considers cost. However, Medicare excludes a number of costs; as a result, CAH's are really paid only 90-95 percent of cost.
Unpaid Medicare costs amount to a subsidy hospitals provide to the Medicare program and are a substantial community benefit.

Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason, decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.

In a 2006 report, the Congressional Budget Office concluded that its study supports using uncompensated care (bad debt and charity care) as a measure of community benefits.

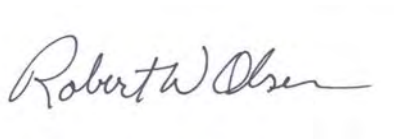
Collecting Pricing Data
The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital. The pricing matrix contained in Schedule H, Part II is unnecessary. Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

The data collected on a historical basis will serve no useful public function. The Form 990 is not an appropriate tool for the public to seek current pricing information about their health care. The Centers for Medicare and Medicaid Services is already working to post price and quality data on the Internet for common services. The effort by the IRS is redundant, at best.

Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

We appreciate the opportunity to comment on the proposed guidelines. Please contact me or John Flink for additional information at (406) 442-1911.

Sincerely,



Robert W. Olsen
Vice President
Regulatory Affairs

From:	Ray Gibbons
To:	*TE/GE-EO-F990-Revision;
CC:	John Flink;
Subject:	Comments on form 990 proposals
Date:	Monday, September 10, 2007 2:02:45 PM
Attachments:	TMC Board Meeting - 10 06.ppt 990 letter.doc image001.jpg

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My comments are attached.

H. Ray Gibbons, FACHE

Administrator/CEO

Teton Medical Center

Voice- 406.466.6001 Fax:406.466.5842

Teton Medical Center

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September 10, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

I appreciate the opportunity to submit comments on the draft redesigned Form 990.

Teton Medical Center is a 12 bed frontier Critical Access Hospital with a 34 bed Skilled Nursing Facility operated in a combined facility model. Teton Medical Center is a government entity by the status of the Teton County Hospital District however, we are in process of applying for a 501-c-3 operating entity for the combined operations. If we are successful in establishing the 501-c-3 operating entity the completion of the Form 990 becomes a reality. It is with this in mind that I make my comments.

Teton Medical Center has provided annual community benefit reports as part of our annual meeting each October. Our community benefit reports provide the amount of detail which is practical for an organization of our size. We do not use the VHA or CHA programs because of their respective costs and lack of staff to complete the extensive data requirements. As a tax supported entity with all of our Board meetings open to the public transparency is really not an issue for Teton Medical Center.

It is always difficult to make one solution “fit” all types of entities particularly hospitals. The critical access hospital program was designed to maintain access in rural and frontier parts of the United States. Critical Access Hospitals like Teton Medical Center struggle with cash flow and because of our environment probably are some of the most transparent hospitals in the United States. Therefore my areas of concern are identified by the following.

Probable Impacts of Proposed Form 990 on Teton Medical Center

- The proposed reporting requirements would impose an unreasonable burden on TMC staff and financial resources to comply at the stated level.
- Schedule H which would require TMC to quantify the community benefits we currently discuss would cost approximately $6000 in software and a .5 FTE of staff time we do not have available. This is excessive expectation of resource use in this one area when our staff needs to be working on keeping current on CMS regulatory impacts.

To address our concerns, I concur with MHA and recommend that

- CAHs be exempted from the community benefit reporting requirement or be required to report based upon metrics currently tracked which do not require speicialized software to maintain. We use a simple Excel spreadsheet..
- The continued operation of Teton Medical Center as a Critical Access Hospital should justify our community benefit and exempt Teton Medical Center from the IRS proposed community benefit reporting.

I agree with the following discussion of additional concerns by MHA:

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

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Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

If you would like additional details or have questions please contact me. If you would like to see a frontier community benefit report I have attached our 2006 report to the electronic response system.

Sincerely,

H. Ray Gibbons, FACHE
Administrator/CEO
406.466.6001